IN THE SUPREME COURT OF FLORIDA

CASE NO. 95,515

FARREN IVEY,

Petitioner,

-vs.-

ALLSTATE INSURANCE COMPANY,

Respondent.

ON PETITION FOR DISCRETIONARY REVIEW FROM THE DISTRICT COURT OF APPEAL, THIRD DISTRICT OF FLORIDA

PETITIONER'S REPLY BRIEF

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CERTIFICATE OF TYPE SIZE AND STYLE

This brief has been prepared using 12 point Courier New font, a font that is not proportionately spaced.

ARGUMENT

I.

THE CIRCUIT COURT APPELLATE DIVISION CORRECTLY REVERSED THE JUDGMENT FOR ALLSTATE BECAUSE ALLSTATE IMPERMISSIBLY FAILED TO MAKE FULL PAYMENT OF ALL PAYABLE PIP BENEFITS WITHIN THIRTY DAYS OF WRITTEN NOTICE OF THE FACT AND AMOUNT OF A COVERED LOSS

Petitioner disagrees with Allstate's characterization of the argument here "that the judge's fact finding was wrong [and] that the circuit court's . . . fact finding was right." There are no facts in dispute here. The evidence is uncontroverted on every major point. There is no doubt but that Plaintiff's physician, Dr. Struhl, performed medical treatment including fourteen units of physiotherapy.[1] Allstate undoubtedly paid for only seven units of therapy until many months later. The trial court's finding that the claim was timely paid is not a factual finding, but an erroneous conclusion of law based on the facts. The circuit court

[1]There is a typo on page 4 of Respondent's brief. On line six, Allstate states that "the $55 was for two units, not one; so there was a total of 4 treatments on 7 days, not 7 . . . ." What Allstate meant to say is that there was a total of **14** treatments, not 7.

appellate division did not engage in fact-finding when it reversed; it applied existing legal principles to undisputed facts to correct the error below.

Allstate suggests that confusion regarding the number of treatments which Dr. Struhl billed to Allstate constitutes a fact issue which the trial court decided in its favor. Allstate insists that Dr. Struhl billed for seven units of physiotherapy, and that the legal result of that "fact" is that the Plaintiff's PIP claim for the additional seven units of treatment was not made (for purpose of starting the 30-day payment period) until Dr. Struhl was deposed months after suit was filed.

But the evidence is clear that Dr. Struhl was billing for all of the fourteen units of physiotherapy he performed, not just for seven. He did so inartfully, but billed for all the treatments. The dispute which Allstate seeks to inject into the case is not a disputed issue of fact, such as how many treatments were performed, or whether the treatments were necessary, but a dispute about what Allstate should have thought and done when it received Dr. Struhl's bill. That is a legal conclusion, based on the undisputed facts, which the trial court erroneously decided.

Allstate would have this case hinge on the reasonableness of its own stated and mistaken belief that Dr. Struhl was billing for

seven units of treatment. Petitioner submits that the real issue, however, is not whether Allstate reasonably misread Dr. Struhl's bill. The issue instead is whether an ambiguity in that bill excused Allstate from its legal duty to investigate and authenticate Plaintiff's claim within thirty days.

There is no principle of PIP law that an ambiguity in the doctor's bill excuses the insurer from taking any action whatsoever to investigate the ambiguity, nor should there be. If an ambiguity in a medical bill permits the insurer to choose the reading which favors it and harms the insured--then immunizes the insurer from its statutory liability to timely pay a claim--there would be no incentive for insurers to use their resources to investigate the claim at all. They instead will always choose to stick their heads in the sand and read the bills in the way that favors them. If all the insurer would have to do to win the PIP lawsuit would be to convince the county court judge that their interpretation of the bill was subjectively reasonable--without so much as calling the doctor's office to ask about the ambiguity--it would throw out the window many years of developing law on the duty of insurers to timely verify PIP claims.

Allstate tries to put its own spin on the facts in order to deny the existence of an ambiguity in the bill and support the

result in its favor. On page 4 of its brief, Allstate makes a statement about Dr. Struhl's bill which indicates that there is no other way to view it, but which is only one way of looking at that bill. The bill is (at least) equally susceptible of another interpretation. Allstate says that Dr. Struhl's "papers showed '1' written in for number of units" of physiotherapy treatment which Dr. Struhl performed each time he saw the Plaintiff. However, the column under which the 1 was written in states at the top: "DAYS OR UNITS." App.4, 5.[2]

The entries of the number 1 under that column did not necessarily show that the number of "units" of electrical stimulation therapy was 1; the charge could well have been for 1 "day" of such therapy. That is the way the doctor himself intended the entry to mean; when asked at his deposition if his bill was for $55 per "unit" of physiotherapy, he responded as follows:

> A. No, $55 for one day. It says days or units. Did you forget to write days in?
>
> Q. I'm sorry.
>
> A. Look right there in the box. It says days or units and you're saying its units. I'm saying its days.

[2] Citations are to Respondent's Appendix.

Struhl depo. at 38 (emphasis added).

There is no way to tell for sure from the form itself whether the entries were for units of treatment or for days of treatment. Allstate did not investigate the ambiguity before unilaterally deciding that the 1 meant "units," allowing it to discount the charges to pay for only half of the number of treatments which actually were rendered. There was, however, other evidence on the claim form from which Allstate should have been aware that Dr. Struhl was treating two different parts of the Plaintiff's body on each visit, not just one.

Immediately above the columns where the medical procedures are listed and the controversial "1" appears, there is a box on the form for the doctor to write in the medical condition for which he is treating the patient. Dr. Struhl wrote two diagnoses on two seperate lines. The first line reads: "Contusion moderate left lower leg." App.4 The second line reads: "Contusion and sprain right shoulder."

The instructions printed on the form, in the box where the doctor is to write the "nature of illness or injury," include the specific instruction for the doctor to "RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1 2 3 ETC. OR DX CODE." App.4 (emphasis added). Dr. Struhl did not use such reference

numbers to indicate that he was only treating one of Plaintiff's two injured areas with the procedures for which he billed Allstate. Thus, Petitioner submits that it was more reasonable to read the claim form as charging for one day of treatment to two areas of the Plaintiff's body, rather than to read it as simply charging for a single unit of therapy each day, while leaving the other injured area of Plaintiff's body untreated.

This case should not boil down to a question of which interpretation of Dr. Struhl's bill is more reasonable. The duty was on Allstate to investigate and verify the amount claimed. E.g., Fortune Inso. v. Pacheco, 695 So. 2d 394 (Fla. 3d DCA 1997); Martinez v. Fortune Ins. Co., 684 So. 2d 201 (Fla. 4th DCA 1996).

Perhaps it is theoretical that there could be a case in which the insurer's mistaken reading of a doctor's bill is the only possible reading, and that the insurer might be excused temporarily from its statutory duty until the mistake came to light.[3] For example, what should be the result where a doctor's bill unambiguously said that he provided "one unit" of therapy (not "days or units"), and only indicated that he was treating one part of the insured's body? That harder issue is not involved here and

[3]Petitioner does not concede as much, but merely muses about the possibility.

need not be decided.

Here the claim did not unambiguously seek payment for only seven units of therapy to one of the two body parts Dr. Struhl was treating. Whether Allstate reasonably misread the bill that way is not material. The ambiguity in the bill found by the trial court did not discharge Allstate of its statutory duty. The burden was on Allstate to investigate the claim within thirty days. Allstate should have called the doctor's office. It should have read his medical report. Allstate should have asked Ms. Ivey what treatments she received. It did nothing. The Third District's decision should be quashed.

II.

PLAINTIFF WAS ENTITLED TO JUDGMENT IN HER FAVOR BECAUSE ALLSTATE CONFESSED JUDGMENT BY VOLUNTARILY PAYING THE BALANCE OF THE CLAIM AFTER SUIT WAS FILED

Allstate puts all its eggs in one basket by arguing that its voluntary payment of the claim was not a confession of judgment because "this claim was not made until November, 1995," when Dr. Struhl's deposition was taken. *See* Answer Brief at 40. The fallacy with that argument is that it places the burden on the insured, Ms. Ivey, to make her claim in the precise manner which

the insurance company says it needs. Absent precision in presenting the claim, Allstate argues, there is no duty to investigate the validity of the amount of the claim and any payment thereafter does not constitute a confession of judgment.

The law is clear that the insured is not obligated to provide proof of a loss or all supporting medical records to justify the loss; the burden is on the insurance company to verify the loss after receiving written notice thereof. *See Fortune Ins. Co. v. Pacheco,* 695 So.2d 22 (Fla. 3d DCA 1997); *Martinez v. Fortune Ins. Co.*, 684 So. 2d 201 (Fla. 4th DCA 1996). The claim was made when Plaintiff submitted Dr. Struhl's bill in the total amount of all of the therapy treatments. Allstate's argument that there was no "claim" because it was not specific enough about the number of treatments which were rendered is specious; the burden was on Allstate to investigate the claim and to correctly determine the amount of its liability, or face responsibility to pay Plaintiff's attorney's fees.

The trial court could not, as a matter of law, find that Allstate's voluntary payment of the balance of Plaintiff's claim did not entitle her to attorney's fees. Although this Court in *Wollard v. Lloyd's and Companies of Lloyd's*, 439 So. 2d 217 (Fla. 1983) speaks of the voluntary payment as being the "functional

equivalent" of a confession of judgment, no such confession of judgment is necessary to support (in fact, to mandate) an award of attorney's fees following voluntary payment.

The Florida Statute permitting an insured to recover attorney's fees from his or her insurer, §627.428, Fla. Stat., "becomes a part of every insurance policy of which the insurer is bound to take notice as it does any other provision of the policy." *Gibson v. Walker,* 380 So. 2d 531, 533 (Fla. 5th DCA 1980). As such, the insured's claim for attorney's fees is just another claim for benefits under the policy when the conditions exist entitling the insured to such a benefit.

Those conditions exist upon the insurance company's voluntary payment after suit is filed, regardless of the insurer's good faith or bad faith in originally defending the claim, and regardless of whether the insurer is "confessing" judgment or not. It is simply the law "that the statutory obligation for attorney's fees cannot be avoided simply by paying the policy proceeds after suit is filed but before a judgment is actually entered, because to so construe the statute would do violence to its purpose, which is to discourage litigation and encourage prompt disposition of valid insurance claims without litigation." *Id.*

Litigation would not have been necessary in the present case

if, upon receiving Ms. Ivey's claim for Dr. Struhl's medical bills, Allstate had directed one of its personnel to simply call Dr. Struhl and ask how many units of physiotheraphy treatment he rendered. Likewise, Allstate simply could have looked at the doctor's report, rather than simply focusing on the single sheet of paper which it claims created the ambiguity immunizing it from its statutory liability for fees. It did none of those things, nor did it ask for further information from the Plaintiff herself before arbitrarily reducing the amount of Dr. Struhl's bill. Therefore, litigation was necessary, and the voluntary payment by Allstate thereafter entitled Ms. Ivey to her attorney's fees.

III.

THE THIRD DCA ERRONEOUSLY APPLIED AN IMPERMISSIBLE STANDARD OF REVIEW UPON CERTIORARI

Allstate misunderstands Ms. Ivey's argument concerning the Third District's erroneous application of the standard of review applicable to certiorari cases. Ivey did not argue in her jurisdictional brief, as Allstate mistakenly states in its Answer Brief on the Merits, "that the Third District did not follow the *Fortune Insurance Company v. Everglades Diagnostics, Inc.,* 721 So. 2d 384 (Fla. 4th DCA 1998) review standard." Ivey argued just the

contrary in her jurisdictional brief, that the Third District in this case ***did*** apply the Fourth District's incorrect simple error test in this PIP case. *Fortune v. Everglades* was not cited to create conflict between the Third District's decision in Ivey and *Fortune*, but merely to show the incorrect legal standard that the Third District was applying in Ivey, "deem[ing] an erroneous interpretation of this [PIP] law to be important enough for certiorari." 721 So. 2d 384 at n.2. That is an incorrect standard for certiorari review of circuit court appellate decisions, and both the Third District and Fourth District are in conflict with the decisions of this Court and other districts applying the correct standard.

That standard, of course, precludes a second appeal based upon a simply erroneous application of the correct body of law. Therefore, wholly apart from the correctness or incorrectness of the circuit court appellate division's decision on the merits, the Third District's decision should be quashed.

CONCLUSION

The Third District's decision should be quashed under any of three analyses. Allstate impermissibly failed to make full payment of PIP benefits due within thirty days of notice of the loss;

Allstate effectively confessed judgment by voluntarily paying the claim after suit was filed; and the Third DCA erroneously applied an impermissible standard of review in granting certiorari.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that true copies hereof were served by United States mail, upon Frank S. Goldstein, Green, Murphy, Wilke &

Murphy, P.A., Suite 200, 633 South Andrews Avenue, Ft. Lauderdale, Florida 33301; Richard A. Sherman, Richard A. Sherman, P.A., 1777 South Andrews Avenue, Suite 302, Ft. Lauderdale, Florida 33316, and Dean A. Mitchell, 4939 NW 115th Avenue, Ocala, FL 33482 on this, the 6th day of December, 1999.

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